

# Summary of Benefits

This section summarizes your UMP PPO benefits. UMP PPO covers only medically necessary services and supplies, as defined on pages 75-76. Please refer to “Covered Expenses” as well as “Expenses Not Covered, Exclusions, and Limitations” for more details.

Please note that UMP PPO has no waiting period for coverage of pre-existing health conditions.

For any UMP PPO benefit, once you have met the cost-sharing requirements, the plan pays at the levels shown on the following summary charts, subject to any benefit maximums or limits indicated. The percentage paid by the plan refers to percentage of the allowed charge only. The remaining amount of the allowed charge is your enrollee coinsurance (defined on page 73).

*The fact that a provider orders a test or prescribes a treatment does not necessarily mean that it is covered by UMP. Please consult this Certificate of Coverage, or call UMP Customer Service if you have questions about whether a service or supply is covered.*

Only the allowed charge is covered—the maximum payment the plan allows for a specific service or supply (see definition on page 71). In many cases, the UMP’s allowed charge is less than the provider’s billed charge for the service. If you use non-network or out-of-network providers, you will also be responsible for the difference between the provider’s billed charge and the UMP allowed charge for the particular service (that is, in addition to UMP PPO cost-sharing requirements). Network providers have agreed to accept the UMP allowed charge as payment in full; out-of-network and non-network providers have not. See pages 14-15 for more information on your provider options.

In most circumstances, UMP PPO follows Medicare coverage guidelines, payment policies, and billing requirements.

Some services also have specific limits, as shown in the summary charts.

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**If you also have Medicare coverage, see “UMP Provisions for Retirees on Medicare” on page 59.**

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The following sections describe your UMP PPO benefits along with other details you’ll need to use the plan effectively. If you have questions, see the Directory (inside the front cover) for contact information.

*For more information on what isn’t covered and benefit limits, see “Summary of Benefits” and “Expenses Not Covered, Exclusions, and Limitations.”*

# Summary of Benefits

All covered benefits are subject to the annual medical/surgical deductible unless otherwise noted. **Percentages shown in chart apply to the UMP allowed charge, which is the amount agreed upon by UMP network providers.**

Benefits	Plan payment for network providers	Plan payment for non-network providers**	Preauthorization required?	See page***
<b>Acupuncture</b> 16 treatments max/year	90%	60%	No	25, 46
<b>Ambulance</b>				25-26, 46
Air and ground	80%	80%	No	
<b>Biofeedback</b> (if for mental health diagnosis, see "Mental Health Treatment" on page 32)	90%	60%	No	26, 32
<b>Blood and Blood Derivatives</b>	90%	60%	Only for stem cell harvesting for transplant purposes	26
<b>Bone, Eye, and Skin Bank Services</b>	90%	60%	No	26
<b>Cardiac and Pulmonary Rehabilitation</b>	90%	60%	Yes	19, 26
<b>Chemical Dependency Treatment</b> \$13,000 maximum plan payment per consecutive 24 calendar month period for in-patient and outpatient treatment combined (\$13,000 limit excludes detox if you haven't been admitted to a chemical dependency program when receiving those services)				26, 46, 72
• <b>Inpatient</b>	100% after \$200 copay/day; \$600 max copay/person/year	60%	No	
• <b>Outpatient</b>	90%	60%	No	
<b>Diabetes Education</b> See page 27.	90%	60%	No	27, 46
<b>Diagnostic Test, Laboratory, and X-Rays</b> (outpatient)	90%	60%	Certain services	28, 48
<b>Dialysis</b>	90%	60%	No	28
<b>Durable Medical Equipment, Supplies, and Prostheses</b> <b>Note:</b> For a wig or hairpiece to replace hair lost due to radiation or chemotherapy, \$100 lifetime max.	90%	60%	Yes, for rentals over 3 months and purchases over \$1,000	18-19, 29, 47, 73

\*Not subject to the annual medical/surgical deductible.

\*\* Your cost-share for these services does not count towards the annual medical/surgical out-of-pocket limit, and is exempt from that limit. See exception for out-of-network care on page 15.

\*\*\* Several exclusions listed in "Expenses Not Covered, Exclusions, and Limitations," may apply to all benefits. Please review the "Expenses Not Covered, Exclusions, and Limitations" section carefully.

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<b>Emergency Room (ER)</b> ER copay waived if admitted directly from ER; copay does not count toward the annual medical/surgical deductible or medical/surgical out-of-pocket limit.	90% after \$75** copay/visit	80% after \$75** copay/visit	No	29, 75
<b>Hearing Care</b> \$400 max/36 months applies to routine hearing exam, hearing aid, and rental/repair combined	90%	60%	No	29, 47
<b>Home Health Care</b>	90%	60%	Yes	19, 30, 47, 74
<b>Hospice Care</b> Six months maximum benefit				19, 30, 47, 74
<ul style="list-style-type: none"> <li>• <b>Inpatient</b>  When preauthorized  When NOT preauthorized </li> <li>• <b>Respite care</b> (\$5,000 lifetime max)</li> </ul>	100% 90% 100%	60% 60% 60%	Yes No Yes	
<b>Hospital Services</b>				
<ul style="list-style-type: none"> <li>• <b>Inpatient</b>  Facility services  <i>May not include doctors' and other professional services</i>    Professional services  <i>See pages 30-31 for important information</i> </li> <li>• <b>Outpatient</b></li> </ul>	100% after \$200 copay/day; \$600 max copay/person/year  90% 90%	60%  60% 60%	No; see "Physical, Occupational, and Speech Therapy" for exceptions. No No	30, 48  31
<b>Mammograms</b>				
<ul style="list-style-type: none"> <li>• <b>Screening mammograms*</b> (beginning at age 40, every one or two years)</li> <li>• <b>Diagnostic mammograms</b></li> </ul>	100% 90%	60% 60%	No No	28, 43 28

(continued on next page)

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## Summary of Benefits, continued

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Benefits	Plan payment for network providers	Plan payment for non-network providers**	Preauthorization required?	See page***
<b>Massage Therapy</b> 16 visits max/year	90%	Not applicable; <b>massage therapists must be network providers to be covered.</b>	Only for services exceeding one hour per session. Treatment plan required.	19, 31, 48
<b>Mastectomy and Related Services</b>	90%	60%	No	31
<b>Mental Health Treatment</b>				19, 32, 48, 49
• <b>Inpatient:</b> 10 days max/year	100% after \$200 copay/day; \$600 max copay/person/year	60%	Only for partial hospitalization services	
• <b>Outpatient:</b> 20 visits max/year	90%	60%	No	
<b>Naturopathic Physician Services</b>	90%	60%	No	33, 46, 47
<b>Neurodevelopmental Therapy</b> (Ages 6 years and under)				33, 48
• <b>Inpatient:</b> 60 days max/year	100% after \$200 copay/day; \$600 max copay/person/year	60%	No	
• <b>Outpatient:</b> 60 visits max/year for all therapies combined	90%	60%	No, but treatment plan required	
<b>Obstetric and Newborn Care</b>				33
• <b>Inpatient</b>				
Facility charges	100% after \$200 copay/day; \$600 max copay/person/year (Routine newborn nursery care is not subject to copay.)	60%	No	
Professional services	90%	60%	No	
• <b>Outpatient</b>	90%	60%	No	
<b>Office, Clinic, and Hospital Visits</b>	90%	60%	No	34, 46, 48

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<b>Benefits</b>	<b>Plan payment for network providers</b>	<b>Plan payment for non-network providers**</b>	<b>Preauthorization required?</b>	<b>See page***</b>
<b>Organ Transplants</b>				19, 34, 48
• <b>Inpatient</b>				
Facility charges	100% after \$200 copay/day; \$600 max copay/person/year	60%	Yes	
Professional services	90%	60%	Yes	
• <b>Outpatient</b>				
Donor search (bone marrow, stem cell, umbilical cord) is limited to 15 searches per transplant	90%	60%	Yes	
<b>Out-of-Network Care</b> Includes care obtained in locations without access to network providers, including the Idaho counties of Bonner, Kootenai, Latah, and Nez Perce	Not applicable	80%	Varies by service/supply	15, 77
<b>Outpatient/Day Surgery, Ambulatory Surgical Center (ASC)</b>	90%	60%	No	35, 49
<b>Phenylketonuria (PKU) Supplements</b>	90%	60%	No	35
<b>Physical, Occupational, and Speech Therapy</b>				19, 35
• <b>Inpatient:</b> 60 days max/year for all therapies combined	100% after \$200 copay/day; \$600 max copay/person/year	60%	Yes	
• <b>Outpatient:</b> 60 visits max/year for all therapies combined	90%	60%	No, but treatment plan required	

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<b>Prescription Drugs*</b> (up to a 90-day supply for most drugs) <ul style="list-style-type: none"> <li>• <b>Retail pharmacies**:</b> Annual prescription drug deductible applies. After you meet your annual prescription drug deductible, your cost-share limit for Tier 1 and Tier 2 drugs is: \$75 per prescription for up to 30 days' supply, \$150 per prescription for 31-60 days' supply, and \$225 per prescription for 61-90 days' supply. Limit does not apply to Tier 3 drugs and prescription drug claims submitted by the enrollee.</li> </ul>				20-24, 36-38, 46, 47, 48, 49
<b>Tier 1:</b> Generic drugs, all insulin, all disposable diabetic supplies, and certain specialty drugs (see page 24)	90% (enrollee coinsurance is 10% or cost-share limit, whichever is less)	90%	Certain drugs	
<b>Tier 2:</b> Preferred brand-name drugs	70% (enrollee coinsurance is 30% or cost-share limit, whichever is less)	70%	Certain drugs	
<b>Tier 3:</b> Nonpreferred brand-name drugs and compounded drugs	50%	50%	Certain drugs	
<ul style="list-style-type: none"> <li>• <b>Mail-service pharmacy**:</b> Annual prescription drug deductible applies. If the actual price of the medication is less than the standard copay, you pay a minimum charge of \$8.99 or the cost of the drug, whichever is greater—but not more than the standard copay.</li> </ul>				
<b>Tier 1:</b> Generic drugs, all insulin, all disposable diabetic supplies, and certain specialty drugs (see page 24)	100% after \$10 copay/refill	See note below	Certain drugs	
<b>Tier 2:</b> Preferred brand-name drugs	100% after \$40 copay/refill	See note below	Certain drugs	
<b>Tier 3:</b> Nonpreferred brand-name drugs and compounded drugs	100% after \$100 copay/refill	See note below	Certain drugs	

**Please note: If you purchase prescription drugs from a mail-order or Internet pharmacy other than Express Scripts and submit claims yourself, prescription drug benefits will be paid as for a non-network retail pharmacy (see pages 20-21).**

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<b>Preventive Care*</b> Only certain services are covered as preventive care. See lists of covered services on pages 39-43.	100%	60%	No	38-43, 46
<b>Radiation and Chemotherapy</b>	90%	60%	No	44
<b>Second Opinions</b> <ul style="list-style-type: none"> <li>• When required by UMP*</li> <li>• When optional</li> </ul>	100%	100%	No	44
<b>Skilled Nursing Facility</b> 150 days max/year	100% after \$200 copay/day; \$600 max copay/person/year	60%	Yes	19, 44, 48, 49
<b>Spinal and Extremity Manipulations</b> 10 visits max/year	90%	60%	No	44, 48
<b>Temporomandibular Joint (TMJ) Treatment (surgical)</b>	90%	60%	Yes	19, 45
<b>Tobacco Cessation Program*</b> <i>Free &amp; Clear</i> program only	100%	Not covered	No	45, 49
<b>Vision Care*</b> <ul style="list-style-type: none"> <li>• <b>Eye exams</b> (routine) Once per calendar year</li> <li>• <b>Vision hardware</b> Including frames, lenses, contact lenses, and fitting fees combined</li> </ul>	90%	60%	No	45, 48, 49
<b>Well-Baby Preventive Care Services*</b> See specific services covered under "Preventive Care"	100%	60%	No	39-41, 46

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